CHAPTER 92-01-02
RULES OF PROCEDURE - NORTH DAKOTA WORKERS' COMPENSATION ACT

92-01-02-01. Definitions.

1. "Act" means the North Dakota Workers' Compensation Act.

2. "Organization" means workforce safety and insurance.

History: Amended effective August 1, 1987; January 1, 1994; April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-02. Claims - Forms. Repealed effective July 1, 2006.

92-01-02-02.1. Temporary partial disability benefits. If, after a compensable injury, a claimant cannot return to full-time employment, or returns to

work at a wage less than that earned at the time of the claimant's first or recurrent disability, the claimant is eligible for a temporary partial disability benefit. Pursuant to North Dakota Century Code section 65-05-10, the temporary partial disability rate is to be fixed by the organization.

1. Should the claimant's postinjury earnings equal or exceed ninety percent of the claimant's earnings at the time of the first or recurrent disability, no benefits will be paid.

2. A claimant may earn up to ten percent of the claimant's preinjury wages without the organization reducing temporary total disability benefits; however, all postinjury wages, from any source, must be reported to the organization to determine whether a reduction is required.

History: Effective June 1, 1990; amended effective April 1, 1997; February 1, 1998; July 1, 2006.
General Authority: NDCC 65-02-08, 65-05-10
Law Implemented: NDCC 65-02-08, 65-05-09

92-01-02-02.2. Additional twenty-five percent rehabilitation allowance benefit payment. Repealed effective January 1, 1996.

92-01-02-02.3. First report of injury.

1. An employer's notice of injury filed with the organization pursuant to North Dakota Century Code section 65-05-01.4 must be the first report of injury form or any other written submission which clearly contains at least the following information:

   a. The injured worker's name and address.

   b. The injured worker's social security number.

   c. The employer's name and address.

   d. The employer's workers' compensation account number.

   e. A description of the nature of the injury.

   f. The location where the injury occurred.

   g. A description of how the injury occurred.

   h. A description of the type of work done by the injured worker.

   i. The name and address of the injured worker's medical provider, if known.

   j. The names and addresses of any witnesses to the injury, if known.

2. Following receipt of the employer's notice of injury, the organization shall determine whether a claim has been filed by the injured worker. If no claim has been filed, the organization shall notify the injured worker by regular mail addressed to the worker at the address given by the employer or at the last-known address of the worker that the employer's notice has been received and shall inform the worker of the filing requirements of North Dakota Century Code section 65-05-01.

History: Effective January 1, 1996; amended effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-01.4, 65-05-01.5

92-01-02-03. Informal hearing. Repealed effective April 1, 1997.

92-01-02-04. Rehearing - Formal hearing. Repealed effective April 1, 1997.

92-01-02-05. Notice of formal hearing - Specification of issues. Repealed effective April 1, 1997.

92-01-02-06. Evidence. Repealed effective April 1, 1997.

92-01-02-07. Subpoena - Depositions. Repealed effective April 1, 1997.

92-01-02-08. Information not presented at a formal hearing. Repealed effective April 1, 1997.

92-01-02-09. Decision. Repealed effective April 1, 1997.

92-01-02-10. Appeal. Repealed effective April 1, 1997.

92-01-02-11. Attorneys. Any party has a right to be represented by an attorney at any stage in the proceedings regarding a claim. An attorney who represents an injured worker in a proceeding regarding a claim shall file a notice of legal representation prior to or together with the attorney's first communication with the organization. If a notice of legal representation is filed subsequently by another attorney, a notice of withdrawal must be filed by the attorney of record before the subsequent attorney may represent the claimant.

History: Amended effective June 1, 1990; April 1, 1997.
General Authority: NDCC 65-02-08, 65-10-03
Law Implemented: NDCC 65-02-08, 65-10-03

92-01-02-11.1. Attorney's fees. Upon receipt of a certificate of program completion from the office of independent review, fees for legal services provided by employees' attorneys and legal assistants working under the direction of employees' attorneys will be paid when an administrative order reducing or denying benefits is submitted to administrative hearing, district court, or supreme

court and the employee prevails; or when a managed care decision is submitted to binding dispute resolution and the employee prevails subject to the following:

1. The organization shall pay attorneys at one hundred twenty-five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at sixty dollars per hour.

2. The organization may pay legal assistants and third-year law students or law school graduates who are not licensed attorneys who are practicing under the North Dakota senior practice rule acting under the supervision of employees' attorneys up to sixty dollars per hour for all actual and reasonable time other than travel time. The organization shall pay travel time at thirty dollars per hour. A "legal assistant" means any person with a bachelor's degree, associate's degree, or correspondence degree in a legal assistant or paralegal program from an accredited college or university or other accredited agency, or a legal assistant certified by the national association of legal assistants or the national federation of paralegal associations. The term may also include a person employed as a paralegal or legal assistant who has a bachelor's degree in any field and experience working as a paralegal or legal assistant.

3. Total fees paid by the organization for all legal services in connection with a dispute regarding an administrative order may not exceed the following:

   a. Except for an initial determination of compensability, twenty percent of the additional amount awarded.

   b. Two thousand five hundred dollars, plus reasonable costs incurred, following issuance of an administrative order under North Dakota Century Code chapter 28-32 reducing or denying benefits, for services provided if a hearing request is resolved by settlement or amendment of the administrative order before the administrative hearing is held.

   c. Five thousand one hundred dollars, plus reasonable costs incurred, if the employee prevails after an evidentiary hearing is held. If the employee prevails after an evidentiary hearing and the organization wholly rejects the recommended decision, and the employee appeals from the organization's final order, the organization shall pay attorney's fees at a rate of one hundred twenty-five percent of the maximum fees specified in subdivisions d and e when the employee prevails on appeal, as defined by North Dakota Century Code section 65-02-08, to the district court or to the supreme court. However, the organization may not pay attorney's fees if the employee prevails at the district court but the organization prevails at the supreme court in the same appeal.

d. Five thousand seven hundred dollars, plus reasonable costs incurred, if the employee's district court appeal is settled prior to submission of briefs. Seven thousand six hundred dollars, plus reasonable costs incurred, if the employee prevails after hearing by the district court.

e. Nine thousand three hundred dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. Ten thousand dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

f. One thousand four hundred dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails.

g. Five hundred dollars for review of a proposed settlement, if the employee to whom the settlement is offered was not represented by counsel at the time of the offer of settlement.

h. Should a settlement or order amendment offered during the OIR process be accepted after the OIR certificate of completion has been issued, no attorney's fees are payable. This contemplates not only identical offers and order amendments but those which are substantially similar.

4. The maximum fees specified in subdivisions b, c, d, and e of subsection 3 include all fees paid by the organization to one or more attorneys, legal assistants, law students, and law graduates representing the employee in connection with the same dispute regarding an administrative order at all stages in the proceedings. A "dispute regarding an administrative order" includes all proceedings subsequent to an administrative order, including hearing, judicial appeal, remand, an order resulting from remand, and multiple matters or proceedings consolidated or considered in a single proceeding.

5. All time must be recorded in increments of no more than six minutes (one-tenth of an hour).

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge, itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The signature of the attorney constitutes a certificate by the attorney that the attorney has not sought or obtained payment, and will not seek payment of any fees or costs from the employee relative to the same dispute regarding an administrative

order. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs will be reimbursed:

   a. Actual postage, if postage exceeds three dollars per parcel.

   b. Actual toll charges for long-distance telephone calls.

   c. Copying charges, at eight cents per page.

   d. Mileage and other expenses for reasonable and necessary travel. Mileage and other travel expenses, including per diem, must be paid in the amounts that are paid state officials as provided by North Dakota Century Code sections 44-08-04 and 54-06-09. Out-of-state travel expenses may be reimbursed only if approval for such travel is given, in advance, by the organization.

   e. Other reasonable and necessary costs, not to exceed one hundred fifty dollars. Other costs in excess of one hundred fifty dollars may be reimbursed only upon agreement, in advance, by the organization. Costs for typing and clerical or office services will not be reimbursed.

8. The following costs will not be reimbursed:

   a. Facsimile charges.

   b. Express mail.

   c. Additional copies of transcripts.

   d. Costs incurred to obtain medical records.

   e. On-line computer-assisted legal research.

   f. Copy charges for documents provided by the organization.

The organization shall reimburse court reporters for mileage and other expenses, for reasonable and necessary travel, in the amounts that are paid state officials as provided by North Dakota Century Code sections 44-08-04 and 54-06-09.

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994; January 1, 1996; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08, 65-02-15
Law Implemented: NDCC 65-02-08, 65-02-15, 65-10-03

92-01-02-11.2. Attorney time statements. An attorney representing a claimant shall submit to the organization, at least once a month, a statement of the time spent representing that claimant during that month. The statement must include the name and claim number of the claimant represented, the type of work performed, which attorney or legal assistant performed the work, and the dates each service was performed. The organization may not pay fees which were not included on a monthly statement submitted as required by this section.

History: Effective April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-12. Mileage and per diem for travel to and from medical treatment. Workforce safety and insurance recognizes payment for travel to and from medical treatment as a reasonable and necessary medical expense. These expenses will be paid according to North Dakota Century Code section 65-05-28, except that reimbursement for out-of-state lodging may not exceed one hundred twenty-five percent of the allowance for in-state lodging. Intracity mileage may not be reimbursed.

History: Effective August 1, 1988; amended effective April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-28

92-01-02-13. Merger, exchange, or transfer of business.

1. **Definitions.** In this section:

   a. "Business entity" means any form of business organization, including proprietorships, partnerships, limited partnerships, cooperatives, limited liability companies, and corporations.

   b. "Constituent business" means a business entity of which a surviving entity is composed.

   c. "Surviving entity" means the business entity resulting from a merger, exchange, or transfer of business assets from one or more constituent businesses.

2. **Experience rating.** The surviving entity resulting from a merger, exchange, or transfer of business assets will be assigned an experience rating derived from the combined premium, payroll, and loss history of all the accounts involved in the merger, exchange, or transfer. The organization may change the experience rating of the surviving entity.

   If the organization determines a business entity is a continuation or extension of an already existing business entity and not a surviving entity composed of one or more constituent businesses, and the existing business entity is already experience-rated, the experience

rate of the existing business entity will transfer to its continuation or extension. Future experience rates will be calculated using the combined premium, payroll and loss history from the existing business entity and its continuations or extensions.

3. **Compensation coverage.**

   a. The organization may transfer compensation coverage of any constituent business to the surviving entity. The organization may require the surviving entity to provide information on the constituent businesses of which it is comprised and its owners, officers, directors, partners, and managers. If the organization determines a surviving entity is merely a continuation of the constituent business or businesses, the organization may transfer the premium liability to the surviving entity or decline coverage until the delinquency is resolved.

   b. Factors the organization may consider in determining if a surviving entity is a mere continuation of a constituent business include:

      (1) Whether there is basic continuity of the constituent business in the surviving entity as shown by retention of key personnel, assets, and general business operations.

      (2) Whether the surviving entity continues to use the same business location or telephone numbers.

      (3) Whether employees transferred from the constituent business to the surviving entity.

      (4) Whether the surviving entity holds itself out as the effective continuation of the constituent business.

   c. The organization shall calculate premium based on actual taxable payroll for the period of time involved. The organization may prorate the payroll cap based on one-twelfth of the statutory payroll cap per month per employee at the beginning of the period of time involved.

History: Effective June 1, 1990; amended effective January 1, 1992; April 1, 1997; May 1, 2002; July 1, 2004.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-14. Procedure for penalizing employers accounts for failure to pay premium or failure to submit payroll reports.

1. The organization shall bill each employer annually for premiums as provided by North Dakota Century Code chapter 65-04. If an employer has an open account with the organization, the organization may send to the employer annually a form on which the employer shall report payroll expenditures from the preceding payroll year. An electronic report of payroll information in a format approved by the organization is acceptable. The employer shall complete the report and send it to the organization either by regular mail or electronic transmission. The report must be received by the organization by the last day of the month following the expiration date of the employer's payroll period. The organization shall consider an unsigned or incomplete submission to be a failure or refusal to furnish the report. The organization shall send the first billing statement approximately fifteen days after the report is received by the organization, to the employer by regular mail to the employer's last-known address or by electronic transmission. The first billing statement must identify the amount due from the employer and the payment due date. The statement must explain the installment payment option.

2. The payment due date for an employer's account is thirty days from the date of billing indicated on the premium billing statement.

3. If the organization does not receive full payment or the minimum installment payment indicated on the premium billing statement, on or before the payment due date, the organization shall send a second billing statement.

4. If the minimum installment payment remains unpaid thirty days after the organization sends the second billing statement to the employer, the organization shall notify the employer by regular mail to the employer's last-known address or by electronic transmission that:

   a. The employer is in default and may be assessed a penalty of two hundred fifty dollars plus two percent of the amount of premium, penalties, and interest in default;

   b. The employer's account has been referred to the collections unit of the policyholder services department; and

   c. Workforce safety and insurance may cancel the employer's account.

5. The organization may extend coverage by written binder if the organization and the employer have agreed in writing to a payment schedule on a delinquent account. If the employer is in default of the agreed payment schedule, however, that employer is not insured.

6. If the employer's payroll report is not timely received by the organization, the organization shall notify the employer, by electronic transmission or regular mail addressed to the last-known address of the employer of the delinquency. The notification must indicate that the organization may assess a penalty of up to two thousand dollars against the employer's account.

7. If the payroll report is not received within forty-five days following the expiration of the employer's payroll year, the organization shall assess a penalty of fifty dollars. The organization shall notify the employer by electronic transmission or regular mail addressed to the employer's last-known address that the employer is uninsured.

8. At any time after sixty days following the expiration of the employer's payroll year, when the employer has failed to submit a payroll report, the organization may bill the employer at the wage cap per employee using the number of employees reported per rate classification from a previous year of actual or estimated payroll reported to the organization. The organization may also bill an employer account using data obtained from job service North Dakota to bill an employer who has failed to submit a payroll report. An employer whose premium has been calculated under this subsection may submit actual wages on an employer payroll report for the period billed and the organization shall adjust the employer's account. The organization may also cancel the employer's account.

9. If the organization receives an employer payroll report more than sixty days after the expiration of the employer's payroll period, the employer's premium billing due date is fifteen days following the expiration of the employer's payroll period. Any employer account billed without benefit of the employer payroll report has a premium billing due date which is fifteen days following the expiration of the employer's payroll year.

10. If the employer does not have an open account with the organization, the organization shall send the employer an application for coverage by regular mail or by electronic transmission. The organization shall notify the employer of the penalties provided by North Dakota Century Code chapter 65-04 and this section.

11. The employer shall submit the completed payroll report within fifteen days of the organization's request. The organization shall consider an unsigned or incomplete submission to be a failure or refusal to furnish the report. If the payroll report is not timely received by the organization,

the organization may assess a penalty of up to two thousand dollars and shall notify the employer that the employer is uninsured.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; March 1, 2003; July 1, 2006.
General Authority: NDCC 65-02-08, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-15. Altering payroll reporting periods for employers. The organization, upon an employer's request, may alter an employer's payroll reporting period to conform with regular quarter endings (March thirty-first, June thirtieth, September thirtieth, December thirty-first) in cases where an employer's payroll reporting period would not normally coincide with a quarter's end.

History: Effective June 1, 1990.
General Authority: NDCC 65-02-08, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-16. Expiration date change. At an employer's request, the organization may change the expiration date on the employer's account. The organization shall calculate premium based on actual taxable payroll for each employee up to the statutory payroll cap, prorated for the actual number of days in the adjusted payroll period.

History: Effective June 1, 1990; amended effective January 1, 1994; April 1, 1997; May 1, 2002.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-17. Reporting payroll for period of noncompliance. If the noncompliance period of a new account is less than twelve months, the organization must prorate the payroll based on one-twelfth of the statutory payroll cap per employee, per month, for the period of time involved. If the payroll is less than one-twelfth of the statutory payroll cap per employee, per month, the full amount is reportable. An account in noncompliance is uninsured until a completed application for workers' compensation insurance coverage is received by the organization and the premium is paid.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-09-01

92-01-02-18. Experience rating system. The following system is established for the experience rating of risks of employers contributing to the fund:

1. Definitions. In this section, unless the context otherwise requires:

a. "Five-year losses" means the total sum of ratable losses accrued on claims occurring during the first five of the six years immediately preceding the premium year being rated.

b. "Five-year payroll" means the total sum of limited payroll reported for the first five of the six years immediately preceding the premium year being rated.

c. "Five-year premium" means the total sum of earned premium for the first five of the six years immediately preceding the premium year being rated.

d. "Manual premium" means the actual premium, prior to any experience rating, for the premium year immediately preceding the premium year being rated for claims experience.

2. An employer's account is not eligible for an experience rating until the account has completed three consecutive twelve-month payroll periods and has developed aggregate manual premiums of at least twenty-five thousand dollars for the rating period used in developing the experience modification factor.

3. For accounts with ratable manual premium of twenty-five thousand dollars or more:

a. The experience rating must be applied prior to the inception of each premium year for all eligible accounts. A claim is deemed to occur in the premium year in which the injury date occurs.

b. The experience modification factor (EMF) to be applied to the current estimated portion of an employer's payroll report is computed as follows:

(1) Calculate the actual primary losses (A_p), which consist of the sum of those five-year losses, comprising the first ten thousand dollars of each individual claim.

(2) Calculate the actual excess losses (A_e), which consist of the sum of those five-year losses in excess of the first ten thousand dollars of losses of each individual claim.

(3) Calculate the total expected losses (E_t), which are determined by adding the products of the actual payroll for each year of the five-year payroll times the class expected loss rate for each year. The class expected loss rates, taking into consideration the hazards and risks of various occupations, must be those contained in the most recent edition of workforce safety and insurance summary of expected loss rates and information, which is hereby

adopted by reference and incorporated within this subsection as though set out in full.

(4) Calculate the expected excess losses (E_e), which are determined by adding the products of the actual payroll for each year of the five-year payroll times the class expected excess loss rates. The class expected excess loss rates, taking into consideration the hazards and risks of various occupations, must be those contained in the most recent edition of workforce safety and insurance summary of expected loss rates and information, which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(5) Calculate the "credibility factor" (Z) which is the quotient of the total expected losses divided by the sum of the total expected losses plus one million dollars.

(6) The experience modification factor is then calculated as follows:

(a) Add the actual primary losses to the product of the actual excess losses times the credibility factor.

(b) To this sum add the product of the expected excess losses times the difference between one dollar and the credibility factor.

(c) To this sum add twenty thousand dollars.

(d) Divide this total sum by the sum of the total expected losses plus twenty thousand dollars.

The resulting quotient is the experience modification factor to be applied in calculating the estimated premium for the current payroll year.

(7) The formula for the above-mentioned calculation is as follows:

$$EMF = \frac{A_p + (Z \times A_e) + [(1.00 - Z) \times E_e] + \$20{,}000.00}{E_t + \$20{,}000.00}$$

History: Effective June 1, 1990; amended effective July 1, 1993; July 1, 1994; April 1, 1997; July 1, 2001; July 1, 2006.
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-01

92-01-02-18.1. Application of discount to experience rate for employers establishing operations in this state. If an employer who is beginning operations in this state can prove that for similar operations in another jurisdiction the employer received an experience-rate-based discount on workers' compensation premiums in that jurisdiction, the organization may discount that employer's premium in this state. The employer must be setting up a permanent operation and the discount must be part of an economic development package. The discount will be applied after one year. Premium discounts for the employer's second through fourth years of operation in this state will be retrospectively based on the employer's most recent out-of-state experience rate. Premiums for the employer's fifth year of operation in this state will be based on the applicable experience rating programs in this state. The out-of-state employer discount may not exceed the maximum allowable discount under the organization's experience rating plans. An employer who self-insured in another jurisdiction is not eligible for the discount.

History: Effective April 1, 1997; amended effective May 1, 2002; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01, 65-04-17

92-01-02-19. Employer relief after third-party recovery. Upon third-party recovery pursuant to North Dakota Century Code section 65-01-09 in claims which have been accepted by the organization and when the employer's experience rating has been affected, relief will be given to the employer from the date of injury to the balance of the experience rating period. Relief will be given to the extent of the actual net recovery made by or on behalf of the organization, after deduction from the gross recovery of the costs and attorney fees allowable under North Dakota Century Code section 65-01-09.

"Relief will be given" indicates that the amount of money recovered by the organization in a third-party action will be deducted from the amount charged against the employer's experience rating. This may result in a decreased premium for policy periods impacted by the revised experience rates. An account that has been canceled is not entitled to relief under this section.

Relief will also be given to the extent of the employer reimbursement paid by the employer pursuant to North Dakota Century Code section 65-05-07.2, provided that the net recovery made by or on behalf of the organization is equal to or exceeds the total chargeable expenditures made by the organization on the claim plus the reimbursement made by the employer. An employer who has not timely paid reimbursement under North Dakota Century Code section 65-05-07.2 forfeits any right to relief for that reimbursement.

History: Effective June 1, 1990; amended effective January 1, 1996; May 1, 2002; July 1, 2004.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-09, 65-04-04.3, 65-04-17, 65-05-07.2

92-01-02-20. Classification of employments - Premium rates. Classifications and premium rates must be those classifications contained in the documents entitled "Classification Manual" and "Workforce Safety and Insurance Rates". When classifying employment or assigning a premium rate, the organization must use the edition of the manuals in effect during the policy period in which the premium is incurred.

Premium rates must be adjusted annually as recommended by the organization's actuaries based upon the criteria found in North Dakota Century Code section 65-04-01.

History: Effective June 1, 1990; amended effective July 1, 1990; July 1, 1991; July 1, 1992; July 1, 1993; July 1, 1994; July 1, 1996; May 1, 2002; July 1, 2006.
General Authority: NDCC 65-02-08, 65-04-01
Law Implemented: NDCC 65-04-01

92-01-02-21. Employee staffing arrangements. Repealed pursuant to North Dakota Century Code section 28-32-18.1, effective July 16, 2003.

92-01-02-22. Out-of-state injuries. An employee may be deemed to regularly work at or from an employment principally localized in this state as defined in North Dakota Century Code sections 65-08-01 and 65-08.1-01 if the employee's out-of-state injury is sustained under circumstances in which the employee has worked outside this state for a period of not more than thirty consecutive calendar days.

History: Effective July 1, 1991; amended effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

92-01-02-23. Installment payment of premiums.

1. On March thirty-first of each year, the organization shall establish the interest rate to be charged to accounts with policy periods renewing between July first and June thirtieth of the following year, which elect to pay premium by installments. For the purposes of North Dakota Century Code sections 65-04-20 and 65-04-33, the interest rate is the base rate posted by the Bank of North Dakota plus two and one-half percent. The interest rate may not be lower than six percent.

2. Premium subject to installments will be limited to the premium for the advance premium only. Prior period premium deficiencies must be paid in full within the original premium due date.

3. Default of any installment payment causes the entire premium balance to be due immediately.

History: Effective November 1, 1991; amended effective January 1, 1996; May 1, 2002.
General Authority: NDCC 65-02-08, 65-04-20
Law Implemented: NDCC 65-04-20, 65-04-24

92-01-02-23.1. Payment by credit card. The organization, in its sole discretion, may accept payment by credit card for premiums, penalties, interest, reimbursements, or any other payment that is due the organization.

History: Effective January 1, 1996; amended effective April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 54-06-08.2

92-01-02-24. Rehabilitation services.

1. When an employment opportunity suited to an employee's education, experience, and marketable skills is identified within thirty-five miles [56.33 kilometers] from the employee's home, the appropriate priority option must be identified as return to related occupation in the local job pool under subdivision e of subsection 4 of North Dakota Century Code section 65-05.1-01, and relocation expense under subsection 3 of North Dakota Century Code section 65-05.1-06.1 may not be paid.

2. The organization may award services to move an employee's household where the employee has actually located work under subdivision e of subsection 2 of North Dakota Century Code section 65-05.1-06.1 only when the employee identifies the job the employee will perform, the employee's employer, and the employee's destination. A relocation award must be the actual cost of moving the household to the location where work has been obtained. A minimum of two bids detailing the costs of relocation must be submitted to the organization for approval prior to incurring the cost. The organization shall pay per diem expenses, as set forth under subsection 2 of North Dakota Century Code section 65-05-28, for the employee only. Reimbursement for mileage expenses may not be paid for more than one motor vehicle.

3. When the rehabilitation award is for retraining, the organization shall pay the actual cost of books, tuition, and school supplies required by the school. The school must provide documentation of the costs necessary for completion of the program in which the employee is enrolled. Reimbursable school costs may not exceed those charged to other students participating in the same program. The award for school supplies may not exceed twenty-five dollars per quarter or thirty dollars per semester unless the employee obtains prior approval of the organization by showing that the expenses are reasonable and necessary. A rehabilitation award for retraining may include tutoring

assistance to employees who require tutoring to maintain a passing grade. Payment of tutoring services will be authorized when these services are not available as part of the training program. The award for tutoring services may not exceed the usual and customary rate established by the school. Expenses such as association dues or subscriptions may be reimbursed only if that expense is a course requirement.

4. An award for retraining which includes an additional twenty-five percent wage-loss allowance to maintain two domiciles as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 may continue only while the employee is actually enrolled or participating in the training program, and is actually maintaining two domiciles.

5. An employee who is required to be in attendance at a training facility for at least three days a week is determined to be attending on a daily basis for purposes of determining eligibility for the twenty-five percent second domicile allowance.

6. An award of a specified number of weeks of training means training must be completed during the specified period of weeks, and rehabilitation benefits may be paid only for the specified number of weeks of training.

7. The organization may reimburse an employee's travel and personal expenses for attendance at an adult learning center or skill enhancement program at the request of the employee and upon the approval of the claims analyst. All claims for reimbursement must be supported by the original vendor receipt and must be submitted within one year of the date the expense was incurred. The organization shall reimburse these expenses at the rates in effect on the date of travel or the date the expense was incurred at which state employees are paid per diem and mileage, or reimburse the actual cost of meals and lodging plus mileage, whichever is less. Mileage calculations will be based upon atlas or map mileage from city limit to city limit and will not include intracity mileage. The organization may not reimburse mileage or travel expenses when the distance traveled is less than fifty miles one way, unless the total mileage in a calendar month equals or exceeds two hundred miles.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; February 1, 1998; May 1, 2002; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1

92-01-02-25. Permanent impairment evaluations and disputes.

1. Definitions:

a. Amputations and loss as used in subsection 11 of North Dakota Century Code section 65-05-12.2.

"Amputation of a thumb" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the second or distal phalanx of the thumb" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of the first finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the first finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the third or distal phalanx of the first finger" means disarticulation at or proximal to the distal interphalangeal joint.

"Amputation of the second finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the second finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the third or distal phalanx of the second finger" means disarticulation at or proximal to the distal interphalangeal joint.

"Amputation of the third finger" means disarticulation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the third finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the fourth finger" means disartriculation at the metacarpal phalangeal joint.

"Amputation of the middle or second phalanx of the fourth finger" means disarticulation at or proximal to the proximal interphalangeal joint.

"Amputation of the leg at the hip" means disarticulation at or distal to the hip joint (separation of the head of the femur from the acetabulum).

"Amputation of the leg at or above the knee" means disarticulation at or proximal to the knee joint (separation of the femur from the tibia).

"Amputation of the leg at or above the ankle" means disarticulation at or proximal to the ankle joint (separation of the tibia from the talus).

"Amputation of a great toe" means disarticulation at the metatarsal phalangeal joint.

"Amputation of the second or distal phalanx of the great toe" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of any other toe" means disarticulation at the metatarsal phalangeal joint.

"Loss of an eye" means enucleation of the eye.

b. "Maximum medical improvement" means the injured employee's recovery has progressed to the point where substantial further improvement is unlikely, based on reasonable medical probability and clinical findings indicate the medical condition is stable.

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between doctors arising from the evaluation that affects the amount of the award. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, fifth edition.

d. "Potentially eligible for an impairment award" means the medical evidence in the claim file indicates an injured employee has reached maximum medical improvement and has a permanent impairment caused by the work injury that will likely be in excess of fifteen percent whole body.

e. "Treating doctor" means a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist acting within the scope of the doctor's license who has physically examined or provided direct care or treatment to the injured employee.

2. Permanent impairment evaluations must be performed in accordance with the American medical association guides to the evaluation of permanent impairment, fifth edition, and modified by this section. All permanent impairment reports must include the opinion of the doctor on the cause of the impairment and must contain an apportionment if

the impairment is caused by both work-related and non-work-related injuries or conditions.

3. The organization shall establish a list of medical specialists within the state who have the training and experience necessary to conduct an evaluation of permanent impairment. The organization may include in the list medical specialists from other states if there is an insufficient number of specialists in a particular specialty within the state who agree to be listed. When an employee requests an evaluation of impairment, the organization shall schedule an evaluation with a physician from the list. The organization may not schedule a permanent impairment evaluation with the employee's treating doctor. The organization and employee may agree to an evaluation by a physician not on the current list. In the event of a medical dispute, the organization shall furnish the list of appropriate specialists to the employee. The organization and the employee, if they cannot agree on an independent medical specialist, shall choose a specialist by striking names of medical specialists from the appropriate specialty until a name is chosen.

4. Upon receiving a permanent impairment rating report from the doctor, the organization shall audit the report and shall issue a decision awarding or denying permanent impairment benefits.

5. A permanent impairment award may not include a rating due solely to pain, including chronic pain; chronic pain syndrome; pain that is rated under section 13.8, table 13-22, or chapter 18 of the American medical association guides to the evaluation of permanent impairment, fifth edition; or pain beyond the pain associated with injuries and illnesses of specific organ systems rated under other chapters of the fifth edition.

6. Permanent mental and behavioral disorder impairment ratings.

   a. Any physician determining permanent mental or behavioral disorder impairment shall:

      (1) Include in the rating only those mental or behavioral disorder impairments not likely to improve despite medical treatment;

      (2) Use the instructions contained in the American medical association guides to the evaluation of permanent impairment, fifth edition, giving specific attention to:

         (a) Chapter 13, "central and peripheral nervous system"; and

         (b) Chapter 14, "mental and behavioral disorders"; and

      (3) Complete a full psychiatric assessment following the principles of the American medical association guides

to the evaluation of permanent impairment, fifth edition, including:

(a) A nationally accepted and validated psychiatric diagnosis made according to established standards of the American psychiatric association as contemplated by the American medical association guides to the evaluation of permanent impairment, fifth edition; and

(b) A complete history of the impairment, associated stressors, treatment, attempts at rehabilitation, and premorbid history and a determination of causality and apportionment.

b. If the permanent impairment is due to organic deficits of the brain and results in disturbances of complex integrated cerebral function, emotional disturbance, or consciousness disturbance, then chapter 13, "central and peripheral nervous system", must be consulted and may be used, when appropriate, with chapter 14, "mental and behavioral disorders". The same permanent impairment may not be rated in both sections. The purpose is to rate the overall functioning, not each specific diagnosis. The impairment must be rated in accordance with the "permanent mental impairment rating work sheet" incorporated as appendix A to this chapter.

c. The permanent impairment report must include a written summary of the mental evaluation and the "report work sheet" incorporated as appendix A to this chapter.

d. If other work-related permanent impairment exists, a combined whole-body permanent impairment rating may be determined.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; May 1, 1998; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

92-01-02-26. Binding arbitration. Repealed effective July 1, 2006.

92-01-02-27. Medical and hospital fees - Reimbursement methods. Maximum medical and hospital fees paid by the organization, including reimbursement for pharmaceuticals and durable medical equipment, are determined in accordance with the most current edition of the publication entitled "Workforce Safety and Insurance Medical and Hospital Fees" (Fee Schedules). Reimbursement for services and procedures not addressed within the fee schedules will be determined on a "by report" basis, in which case a description of the nature, extent and need for the procedure or service, including the time, skills,

equipment, and any other pertinent facts necessary to furnish the procedure or service, must be provided to the organization.

History: Effective January 1, 1992; amended effective January 1, 1994; October 1, 1998; January 1, 2000; May 1, 2002.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-28. Health care advisory board. Repealed effective October 1, 1998.

92-01-02-29. Medical services - Definitions. The definitions found in North Dakota Century Code title 65 apply to terms contained in this title. In addition, unless the context otherwise requires, for purposes of sections 92-01-02-27 through 92-01-02-48:

1. "Attending doctor" means a doctor who is primarily responsible for the treatment of a claimant's compensable injury.

2. "Bill audit" means the review of medical bills and associated medical records by the organization or the managed care vendor, including review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, coding documentation in accordance with health care finance administration guidelines, coverage, concurrent billing for services for covered and noncovered services, and application of fee schedules.

3. "Case management" means the ongoing coordination of medical services provided to a claimant, including:

   a. Developing a treatment plan to provide appropriate medical services to a claimant.

   b. Systematically monitoring the treatment rendered and the medical progress of the claimant.

   c. Assessing whether alternative medical services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards.

   d. Ensuring the claimant is following the prescribed medical plan.

   e. Formulating a plan for keeping the claimant safely at work or expediting a safe return to work.

4. "Concurrent review" means the monitoring by the organization or the managed care vendor for medical necessity and appropriateness, throughout the period of time in which designated medical services are

being provided to the claimant, of the claimant's condition, treatments, procedures, and length of stay.

5. "Consulting doctor" means a licensed doctor who examines a claimant, or the claimant's medical record, at the request of the attending doctor to aid in diagnosis or treatment. A consulting doctor, at the request of the attending doctor, may provide specialized treatment of the compensable injury and give advice or an opinion regarding the treatment being rendered or considered for a claimant's injury.

6. "Elective surgery" means surgery that may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

7. "Emergency" means a medical condition that manifests itself by symptoms of sufficient severity, which may include severe pain, to cause a prudent layperson possessing an average knowledge of health and medicine to reasonably conclude that immediate medical treatment is required to avoid serious impairment of a bodily function, or serious dysfunction of any body part, or jeopardizing the person's life.

8. "Fee schedule" means the publication entitled "Workforce Safety and Insurance Medical and Hospital Fees".

9. "Functional capacity evaluation" means an objective, directly observed, measurement of a claimant's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the claimant and the evaluator. A physical tolerance screening and a Blankenship's functional evaluation are functional capacity evaluations.

10. "Managed care" means services performed by the organization or a managed care vendor, including utilization review, preservice reviews, disability management services, case management services, ambulatory reviews, concurrent reviews, retrospective reviews, preadmission reviews, and medical bill audit.

11. "Managed care vendor" means an organization that is retained by the organization to provide managed care services.

12. "Medical service" means a medical, surgical, chiropractic, psychological, dental, hospital, nursing, ambulance, and other related or ancillary service, including physical and occupational therapy and drugs, medicine, crutches, a prosthetic appliance, braces, and supports, and physical restoration and diagnostic services, or a service outlined in section 92-01-02-30.

13. "Medical service provider" means a doctor, health care provider, hospital, medical clinic, or vendor of medical services.

14. "Medically stationary" means the "date of maximum medical improvement" as defined in North Dakota Century Code section 65-01-02 has been reached.

15. "Notice of nonpayment" means the form by which a claimant is notified of charges denied by the organization which are the claimant's personal responsibility.

16. "Palliative care" means a medical service rendered to alleviate symptoms without curing the underlying condition.

17. "Physical conditioning" means an individualized, graded exercise program designed to improve the overall cardiovascular, pulmonary, and neuromuscular condition of the claimant prior to or in conjunction with the claimant's return to any level of work. Work conditioning is the same as physical conditioning.

18. "Preservice review" means the evaluation by the organization or a managed care vendor of a proposed medical service for medical necessity, appropriateness, and efficiency prior to the services being performed.

19. "Remittance advice" means the form used by the organization to inform payees of the reasons for payment, reduction, or denial of medical services.

20. "Retrospective review" means the organization's or a managed care vendor's review of a medical service for medical necessity, appropriateness, and efficiency after treatment has occurred.

21. "Special report" means a medical service provider's written response to a specific request from the organization for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" under section 92-01-02-27 are not special reports.

22. "Utilization review" means an evaluation of the necessity, appropriateness, efficiency, and quality of medical services provided to a claimant, based on medically accepted standards and an objective evaluation of the medical services.

23. "Utilization review department" means the organization's utilization review department.

24. "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process which involves the claimant participating in simulated or actual work tasks that are

structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the claimant to a specified job.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.1. Medical necessity.

1. A medical service or supply necessary to diagnose or treat a compensable injury, which is appropriate to the location of service, is medically necessary if it is widely accepted by the practicing peer group and has been determined to be safe and effective based on published, peer-reviewed, scientific studies.

2. Services that present a hazard in excess of the expected medical benefits are not medically necessary. Services that are controversial, obsolete, experimental, or investigative are not reimbursable unless specifically preapproved or authorized by the organization. Requests for authorization must contain a description of the treatment and the expected benefits and results of the treatment.

3. The organization will not authorize or pay for the following treatment:

   a. Massage therapy or acupuncture unless specifically preapproved or otherwise authorized by the organization. Massage therapy must be provided by a licensed physical therapist, licensed occupational therapist, licensed chiropractor, or licensed massage therapist.

   b. Chemonucleolysis; acupressure; reflexology; rolfing; injections of colchicine except to treat an attack of gout precipitated by a compensable injury; injections of chymopapain; injections of fibrosing or sclerosing agents except where varicose veins are secondary to a compensable injury; synvisc injections; viscosupplementation injections; and injections of substances other than cortisone, anesthetic, or contrast into the subarachnoid space (intrathecal injections).

   c. Treatment to improve or maintain general health (i.e., prescriptions or injections of vitamins, nutritional supplements, diet and weight loss programs, programs to quit smoking) unless specifically preapproved or otherwise authorized by the organization. Over-the-counter medications may be allowed in lieu of prescription medications when approved by the organization and prescribed by the attending doctor. Dietary supplements, including minerals, vitamins, and amino acids are reimbursable if a specific

compensable dietary deficiency has been clinically established in the claimant. Vitamin B-12 injections are reimbursable if necessary because of a malabsorption resulting from a compensable gastrointestinal disorder.

d. Articles such as beds, hot tubs, chairs, Jacuzzis, vibrators, heating pads, home furnishings, waterbeds, exercise equipment, cold packs, and gravity traction devices are not compensable except at the discretion of the organization under exceptional circumstances.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.2. Acceptance of rules and fees. Medical service providers rendering treatment of any kind, regardless of the state or country where services are provided, including inpatient and outpatient services, to a claimant who comes under the organization's jurisdiction must comply with managed care services under these rules. All providers shall cooperate with the organization and the managed care vendor and shall provide to the organization or the managed care vendor, without additional charge, the medical information requested in relation to the reviewed service.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-30. Medical services.

1. Medical services.

   a. Medical services that are not medically necessary are not reimbursable.

   b. Frequency and extent of treatment may not be more than the nature of the injury or process of recovery requires, and must be provided in accordance with utilization and treatment standards as prescribed by the organization or the managed care vendor. The organization may require evidence of the efficacy of treatment.

2. Medical services may be reimbursed only when provided according to a written treatment plan. A copy of the treatment plan, signed by the attending medical service provider, must be provided to the organization within fourteen days of beginning the treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later. However, a treatment plan is not required for a short course of treatment consisting of one or two visits.

3. For purposes of this section, a treatment plan must include:

   a. Objectives, including the degree of restoration anticipated.

   b. Measurable goals.

   c. Modalities and specific therapies to be used.

   d. Frequency and duration of treatments to be provided.

   e. Condition of the claimant which may require periodic modification of the plan of care based on:

      (1) Improvements in the claimant's status.

      (2) Failure of the claimant to improve as expected.

      (3) Intervention of care rendered, including education of the claimant, when appropriate.

      (4) Specific operative reports, test results, and consultation reports.

4. The cost of preparing a written treatment plan and supplying progress notes under this section is included in the fee for the medical service.

5. The treatment plan requirements of this section may be modified or waived by the organization.

6. X-ray films must be of diagnostic quality. Billings for x-rays are not reimbursable without a report of the findings. Upon request of either the organization or the managed care vendor, original x-ray films must be forwarded to the organization or the managed care vendor. Films must be returned to the vendor. A reasonable charge may be made for the costs of delivery of films.

7. Unless the ordering physician states "dispense as written", a generic brand of therapeutic equivalence must be dispensed, provided the generic brand costs less. If the injured worker does not accept the generic equivalent at a lower price, the injured worker is responsible for the cost difference between the generic and brand name prescription medication.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-31. Who may be reimbursed.

1. Only treatment that falls within the scope and field of the treating medical service provider's license to practice is reimbursable.

2. Paraprofessionals who are not independently licensed must practice under the direct supervision of a licensed medical service provider whose scope of practice and specialty training includes the service provided by the paraprofessional, in order to be reimbursed.

3. Health care providers may be refused reimbursement to treat cases under the jurisdiction of the organization.

4. Reasons for holding a medical service provider ineligible for reimbursement include one or more of the following:

   a. Failure, neglect, or refusal to submit complete, adequate, and detailed reports.

   b. Failure, neglect, or refusal to respond to requests by the organization for additional reports.

   c. Failure, neglect, or refusal to observe and comply with the organization's orders and medical service rules, including cooperation with the organization's managed care vendors.

   d. Failure to notify the organization immediately and prior to burial in any death if the cause of death is not definitely known or if there is question of whether death resulted from a compensable injury.

   e. Failure to recognize emotional and social factors impeding recovery of claimants.

   f. Unreasonable refusal to comply with the recommendations of board-certified or qualified specialists who have examined the claimant.

   g. Submission of false or misleading reports to the organization.

   h. Collusion with other persons in submission of false or misleading information to the organization.

   i. Pattern of submission of inaccurate or misleading bills.

   j. Pattern of submission of false or erroneous diagnosis.

   k. Knowingly submitting bills to a claimant for treatment of a work-related condition for which the organization has accepted liability, charging or attempting to charge claimants fees in addition

to the fee paid by the organization for care of the occupational injury, or billing the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges.

l. Failure to include physical conditioning in the treatment plan. The medical service provider should determine the claimant's activity level, ascertain barriers specific to the claimant, and provide information on the role of physical activity in injury management.

m. Failure to include the injured worker's functional abilities in addressing return-to-work options during the recovery phase.

n. Treatment that is controversial, experimental, or investigative; which is contraindicated or hazardous; which is unreasonable or inappropriate for the work injury; or which yields unsatisfactory results.

o. Certifying disability in excess of the actual medical limitations of the claimant.

p. Conviction in any court of any offense involving moral turpitude, in which case the record of the conviction is conclusive evidence.

q. The excessive use, or excessive or inappropriate prescription for use, of narcotic, addictive, habituating, or dependency inducing drugs.

r. Declaration of mental incompetence by a court of competent jurisdiction.

s. Disciplinary action by a licensing board.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32. Physician assistant and nurse practitioner rules.

1. Physician assistants and nurse practitioners may be reimbursed within the scope of their licenses for services performed under the supervision of a licensed physician that are required by their licensure.

2. Physician assistant or nurse practitioner fees will be paid at the rate of eighty percent of a doctor's fee for a comparable service. The bills for these services must be marked with modifier NP. Services provided by a physician assistant or nurse practitioner which meet the following

criteria will be reimbursed at one hundred percent of the fee allowed a physician for those services:

a. The services are rendered under the direct supervision of a physician;

b. The services are rendered in a clinical setting as an integral, although incidental, part of the physician's professional services in the course of diagnosis or treatment of an injury or illness; and

c. The physician must be physically onsite when and where service is provided.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-33. Utilization review and quality assurance. The organization has instituted a program of utilization review and quality assurance to monitor and control the use of health care services.

1. Prior authorization for services must be obtained from the organization or its managed care vendor at least twenty-four hours or the next business day in advance of providing certain medical treatment, equipment, or supplies. Medical services requiring prior authorization or preservice review are outlined in section 92-01-02-34. Emergency medical services may be provided without prior authorization, but notification is required within twenty-four hours of, or by the end of the next business day following, initiation of emergency treatment. Reimbursement may be withheld, or recovery of prior payments made, if utilization review does not confirm the medical necessity of emergency medical services.

2. Documentation of the need for and efficacy of continued medical care by the medical service provider is required at the direction or request of the organization or the managed care vendor while a claim is open.

3. The organization may require second opinion consultations prior to the authorization of reimbursement for surgery and for conservative care which extends past sixty days following the initial visit.

4. The organization may use the Official Disability Guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Guide to Physical Therapy Practice, The Medical Disability Advisor, Diagnosis and Treatment for Physicians and Therapists Upper Extremity Rehabilitation, Treatment Guidelines of the American Society of Hand Therapists, or any other

treatment and disability guidelines or standards it deems appropriate to administer claims.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2006.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-34. Treatment requiring authorization, preservice review, and retrospective review.

1. Certain treatment procedures require prior authorization or preservice review by the organization or its managed care vendor. Requests for authorization or preservice review must include a statement of the condition diagnosed; their relationship to the compensable injury; the medical documentation supporting medical necessity, an outline of the proposed treatment program, its length and components, and expected prognosis.

2. Requesting prior authorization or preservice review is the responsibility of the medical service provider who provides or prescribes a service for which prior authorization or preservice review is required.

3. Medical service providers shall request prior authorization directly from the claims analyst for the items listed in this subsection. The claims analyst shall respond to requests within fourteen days.

   a. Durable medical equipment.

      (1) The organization will pay rental fees for equipment if the need for the equipment is for a short period of treatment during the acute phase of a compensable work injury. The claims analyst shall grant or deny authorization for reimbursement of equipment based on whether the claimant is eligible for coverage and whether the equipment prescribed is appropriate and medically necessary for treatment of the compensable injury. Rental extending beyond thirty days requires prior authorization from the claims analyst. If the equipment is needed on a long-term basis, the organization may purchase the equipment. The claims analyst shall base its decision to purchase the equipment on a comparison of the projected rental costs of the equipment to its purchase price. The organization shall purchase the equipment from the most cost-efficient source.

      (2) The claims analyst will authorize and pay for prosthetics and orthotics as needed by the claimant because of a compensable work injury when substantiated by the attending doctor. If those items are furnished by the attending

doctor or another provider, the organization will reimburse the doctor or the provider pursuant to its fee schedule. Providers and doctors shall supply the organization with a copy of their original invoice showing actual cost of the item upon request of the organization. The organization will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the attending doctor that replacement or repair is needed. Prior authorization for replacements is required.

(3) If submitted charges for supplies and implants exceed the usual and customary rates, charges will be reimbursed at the provider's purchase invoice plus twenty percent.

(4) Equipment costing less than five hundred dollars does not require prior authorization. This includes crutches, cervical collars, lumbar and rib belts, and other commonly used orthotics, but specifically excludes ten units.

b. Biofeedback programs; pain clinics; psychotherapy; physical rehabilitation programs, including health club memberships and work hardening programs; chronic pain management programs; and other programs designed to treat special problems.

c. Concurrent care. In some cases, treatment by more than one medical service provider may be allowed. The claims analyst will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system or require specialty or multidisciplinary care. When requesting consideration for concurrent treatment, the attending doctor must provide the claims analyst with the name, address, discipline, and specialty of all other medical service providers assisting in the treatment of the claimant and with an outline of their responsibility in the case and an estimate of how long concurrent care is needed. When concurrent treatment is allowed, the organization will recognize one primary attending doctor, who is responsible for prescribing all medications if the primary attending doctor is a physician authorized to prescribe medications; directing the overall treatment program; providing copies of all reports and other data received from the involved medical service providers; and, in time loss cases, providing adequate certification evidence of the claimant's ability to perform work. The claims analyst will approve concurrent care on a case-by-case basis. Except for emergency services, all treatments must be authorized by the claimant's attending doctor to be reimbursable.

d. Telemedicine. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on"

appointment for the following appointments: office or other outpatient visits that fall within CPT codes 99241 through 99275, inclusive; new and established evaluation and management visits that fall within CPT codes 99201 through 99215, inclusive; individual psychotherapy visits that fall within CPT codes 90804 through 90809, inclusive; and pharmacologic management visits that fall within CPT code 90862. As a condition of payment, the patient must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule amount for the service provided. The organization may pay the originating site a facility fee, not to exceed twenty dollars.

4. Notwithstanding the requirements of subsection 5, the organization may designate certain exemptions from preservice review requirements in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.

5. Medical service providers shall request preservice review from the utilization review department for:

   a. All nonemergent inpatient hospital admissions or nonemergent inpatient surgery and outpatient surgical procedures. For an inpatient stay that exceeds fourteen days, the provider shall request, on or before the fifteenth day, additional review of medical necessity for a continued stay.

   b. All nonemergent major surgery. When the attending doctor or consulting doctor believes elective surgery is needed to treat a compensable injury, the attending doctor or the consulting doctor with the approval of the attending doctor, shall give the utilization review department actual notice at least twenty-four hours prior to the proposed surgery. Notice must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the hospital where surgery is to be performed. When elective surgery is recommended, the utilization review department may require an independent consultation with a doctor of the organization's choice. The organization shall notify the doctor who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days after notice to the attending doctor. Within seven days of the consultation, the organization shall notify the surgeon of the consultant's findings. If the attending doctor and consultant disagree about the need for surgery, the organization may request a third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the organization believes the proposed surgery is excessive, inappropriate, or ineffective and the organization cannot resolve the dispute with the attending doctor, the requesting doctor may

request binding dispute resolution in accordance with section 92-01-02-46.

c. Magnetic resonance imaging, a myelogram, discogram, bonescan, arthrogram, or computed axial tomography. Tomograms are subject to preservice review if requested in conjunction with a myelogram, discogram, bonescan, arthrogram, computed axial tomography scan, or magnetic resonance imaging. The organization may waive preservice review requirements for procedures listed in this subdivision when requested by a doctor who is performing an independent medical examination or permanent partial impairment evaluation at the request of the organization.

d. Physical therapy and occupational therapy treatment beyond the first ten treatments or beyond thirty days after first prescribed, whichever occurs first, or physical therapy and occupational therapy treatment after an inpatient surgery, outpatient surgery, or ambulatory surgery beyond the first ten treatments or beyond thirty days after therapy services are originally prescribed, whichever occurs first. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers.

e. Electrodiagnostic studies, which may only be performed by board-certified or board-eligible electromyographers. Nerve conduction study reports must include normal values in addition to the test values.

f. Thermography.

g. Vertebral axial decompression therapy (Vax-D treatment).

h. Intradiscal electrothermal annuloplasty (IDET).

i. Trigger point injections if more than three injections are required in a two-month period. No more than twenty injections may be paid over the life of a claim. If a trigger point injection is administered, the organization may not pay for additional modalities such as cryotherapy and osteopathic manipulations performed in conjunction with the trigger point injection. For purposes of this paragraph, injections billed under CPT code 20552 or 20553 will count as a single injection. Only injections administered on or after May 1, 2002, will be applied toward the maximum number of injections allowed under this subdivision.

j. Facet joint injections.

k. Sacroiliac joint injections.

l. Facet nerve blocks.

m. Epidural steroid injections.

n. Nerve root blocks.

o. Peripheral nerve blocks.

p. Botox injections.

q. Stellate ganglion blocks.

r. Cryoablation.

s. Radio frequency lesioning.

t. Facet rhizotomy.

u. Prolotherapy.

v. Implantation of stimulators and pumps.

6. Chiropractic providers shall request preservice review from the organization's chiropractic managed care vendor for chiropractic treatment beyond the first twelve treatments or beyond ninety days after the first treatment, whichever occurs first. The evaluation to determine a treatment plan is not subject to review. The organization may waive this subsection in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers.

7. Concurrent review of emergency admissions is required within twenty-four hours, or the next business day, of emergency admission.

8. The organization may designate those diagnostic and surgical procedures that can be performed in other than a hospital inpatient setting.

9. The utilization review department or managed care vendor must respond orally to the medical service provider within twenty-four hours, or the next business day, of receiving the necessary information to complete a review and make a recommendation on the service. Within that time, the managed care vendor must either recommend approval or denial of the request, request additional information, request the claimant obtain a second opinion, or request an examination by the

claimant's doctor. A recommendation to deny medical services must specify the reason for the denial.

10. The organization may conduct retrospective reviews of medical services and subsequently reimburse medical providers only:

    a. If preservice review or prior authorization of a medical service is requested by a provider and a claimant's claim status in the adjudication process is pending or closed; or

    b. If preservice review or prior authorization of a medical service is not requested by a provider and the provider can prove, by a preponderance of the evidence, that the injured employee did not inform the provider, and the provider did not know, that the condition was, or likely would be, covered under workers' compensation.

    All medical service providers are required to cooperate with the managed care vendor for retrospective review and are required to provide, without additional charge to the organization or the managed care vendor, the medical information requested in relation to the reviewed service.

11. The organization must notify provider associations of the review requirements of this section prior to the effective date of these rules.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; March 1, 2003; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-35. Determining medically stationary status. Repealed effective October 1, 1998.

92-01-02-36. Elective surgery. Repealed effective October 1, 1998.

92-01-02-37. Concurrent care. Repealed effective October 1, 1998.

92-01-02-38. Changes of doctors.

1. All changes from one doctor to another must be approved by the organization. Normally, changes will be allowed only after the claimant has been under the care of the attending doctor for sufficient time for the doctor to complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program.

2. North Dakota Century Code section 65-05-28 governs choice of doctor. For purposes of this rule, the following are not considered changes of doctor by the claimant:

   a. Emergency services by a doctor;

   b. Examinations at the request of the organization;

   c. Consultations or referrals initiated by the attending doctor;

   d. Referrals to radiologists and pathologists for diagnostic studies;

   e. When claimants are required to change doctors to receive compensable medical services, palliative care or time loss authorization because their health care provider is no longer qualified as an attending doctor; or

   f. Changes of attending doctor required due to conditions beyond the claimant's control. This would include when the doctor terminates practice or leaves the area.

3. The claimant must be advised when and why a change is denied. The organization reserves the right to require a claimant to select another doctor or specialist for treatment:

   a. When more conveniently located doctors, qualified to provide the necessary treatment, are available;

   b. When the attending doctor fails to observe or comply with the organization's rules;

   c. When, in a time loss case, reasonable progress toward return to work is not shown;

   d. When a claimant requires specialized treatment, which the attending doctor is not qualified to render, or which is outside the scope of the attending doctor's license to practice; or

   e. When the attending doctor is not qualified to treat each of several accepted conditions. This does not preclude concurrent care when indicated as outlined in section 92-01-02-34.

4. When the organization finds the change of doctor to be appropriate and has requested the claimant to change under this rule, the organization may select a new attending doctor if the claimant unreasonably refuses or delays in selecting another attending doctor.

5. The organization in its discretion may authorize a change when it finds that a change is in the best interest of returning the claimant to a productive role in society.

History: Effective January 1, 1994; amended effective April 1, 1997; January 1, 2000.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-39. Hospitalization. Repealed effective October 1, 1998.

92-01-02-40. Palliative care.

1. After the employee has become medically stationary, palliative care is compensable without prior approval from the organization only when it is necessary to monitor administration of prescription medication required to maintain the claimant in a medically stationary condition or to monitor the status of a prosthetic device.

2. If the organization or its managed care vendor believes palliative care provided under subsection 1 is excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services, review must be performed according to section 92-01-02-46.

3. After the claimant has reached medically stationary status and the claimant's doctor believes that palliative care is necessary, the doctor shall request authorization for palliative care through the managed care vendor prior to the commencement of the treatment. If the palliative care request is approved, services are payable from the date the approved treatment begins. The request must:

   a. Contain all objective findings, and specify if there are none.

   b. Identify the medical condition by ICD-9-CM diagnosis for which the palliative treatment is proposed.

   c. Provide a proposed treatment plan that includes the specific treatment modalities, the name of the provider who will perform the treatment, and the frequency and duration of the care to be given.

   d. Describe how the requested palliative care is related to the accepted compensable condition.

   e. Describe how the proposed treatment will enable the claimant to continue employment or to perform the activities of daily living, and what the adverse effect would be to the claimant if the palliative care is not approved.

f. Any other information the organization or managed care vendor may request.

4. The managed care vendor shall approve palliative care only when:

   a. Other methods of care, including patient self-care, structural rehabilitative exercises, and lifestyle modifications are being utilized and documented;

   b. Palliative care reduces both the severity and frequency of exacerbations that are clinically related to the compensable injury; and

   c. Repeated attempts have been made to lengthen the time between treatments and clinical results clearly document that a significant deterioration of the compensable condition has resulted.

5. If the attending doctor does not receive written notice from the organization within thirty days of the receipt of the request for palliative care, which approves or disapproves the care, the request will be considered approved.

6. When the request for palliative care is not approved, the organization shall provide, in writing, specific reasons for not approving the care.

7. When the organization approves or disapproves the requested palliative care, the attending doctor, employer, or claimant may request binding dispute resolution under section 92-01-02-46.

8. For the purposes of this section only, a claimant's condition must be determined to be medically stationary when the attending doctor or a preponderance of medical evidence indicates the claimant is "medically stationary" or uses other language meaning the same thing. When there is a conflict in the medical opinions, more weight must be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and on clear and concise reasoning. When expert analysis is important, deference must be given to the opinion of the doctor with the greatest expertise in the diagnosed condition. The date a claimant is medically stationary is the earliest date that a preponderance is established under this section. The date of the examination, not the date of the report, controls the medically stationary date. When a specific date is not indicated but the medical opinion states the claimant is medically stationary, the claimant is presumed medically stationary on the date of the last examination.

This subsection does not govern determination of maximum medical improvement relating to a permanent impairment award.

History: Effective January 1, 1994; amended effective October 1, 1998; May 1, 2002; July 1, 2004.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-41. Independent medical examinations.

1. The organization may request an independent medical examination pursuant to North Dakota Century Code section 65-05-28:

   a. To establish a diagnosis or to clarify a prior diagnosis that may be controversial or ill-defined.

   b. To outline a program of rational treatment, if treatment or progress is controversial.

   c. To establish medical data from which it may be determined whether the medical condition is related, or not related, to the injury.

   d. To determine whether and to what extent a preexisting medical condition is aggravated by an occupational injury.

   e. To establish when the claimant has reached maximum medical improvement or medically stationary status.

   f. To establish a percentage of rating for permanent impairment.

   g. To determine whether a claim should be reopened for further treatment on the basis of aggravation of a compensable injury or significant change in a medical condition.

   h. To determine whether overutilization by a health care provider has occurred.

   i. To determine whether a change in health care provider is indicated.

   j. To determine whether treatment is necessary if the claimant appears to be making no progress in recuperation.

   k. When the attending doctor has not provided current medical reports.

2. It is the organization's intention to obtain objective examinations to ensure that correct determinations are made of all benefits to which the injured claimant might be entitled.

3. Examiners must be willing to testify or be deposed on behalf of the claimant, employer, or the organization.

4. The organization must provide at least fourteen days' notice to the claimant of an independent medical examination. The organization must reimburse the claimant's expenses for attending the independent medical examination pursuant to North Dakota Century Code section 65-05-28.

History: Effective January 1, 1994; amended effective October 1, 1998.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-42. Durable medical equipment. Repealed effective October 1, 1998.

92-01-02-43. Home nursing care.

1. When the attending doctor believes special or attendant (home nurse) care is needed, the doctor shall submit the following information:

   a. A description of the special or home nursing care required, including the estimated time required (i.e., catheterization, three times per day, thirty minutes; bathing, two times per day, one hour; toilet transfers as needed, dressing change, four times per day, two hours).

   b. The skill level or special training required to administer care (i.e., R.N.; L.P.N.; family member who has received special training; or no special training required).

   c. If known, the name and address of a person or facility willing to provide care.

   d. The length of time special or home nursing care will be required.

2. Fees for home nurse or attendant care are based upon the organization's established fee schedule.

3. The organization may authorize and pay for visiting nurse care necessary for evaluation or instruction of a home health care provider.

4. When the claimant or claimant's family makes arrangements for caregivers, the organization shall reimburse those providing the home nursing care.

5. Payment to individuals who provide services under this section does not constitute an employer and employee relationship between the organization and the provider of care.

6. The organization may not pay a rate for home nursing care which exceeds any rate included in the definition of "average cost of nursing facility care" under section 75-02-02.1-33.1.

History: Effective January 1, 1994; amended effective October 1, 1998; July 1, 2006.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-44. Special programs. The organization may enter into special agreements for services provided by, or under the direction of, licensed providers authorized to bill the organization. Special agreements may be made for services not covered under the fee schedule and may include multidisciplinary or interdisciplinary programs such as pain management, work hardening, and physical conditioning. Special programs include new programs and pilot projects to streamline, waive, or modify selected managed care rules to provide medical care for claimants with greater efficiency.

The organization shall establish payment rates for special agreements and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure claimants receive good quality and effective services at a reasonable cost. The organization may terminate special agreements and programs upon thirty days' notice to the provider.

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45. Organization responsibilities.

1. As soon as reasonably possible after receiving a bill, the organization shall:

   a. Pay the charge or any portion of the bill that is not denied;

   b. Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary; or

   c. Request specific additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

2. The organization shall provide written notice of nonpayment to the claimant when the claimant is personally responsible for the payment of a charge. The organization shall provide written notice of nonpayment to the provider through a remittance advice of denial of part or all of a

charge, or shall provide written notice to the provider for any request for additional information. The written notice must include:

a. The basis for denying all or part of a charge because the treatment was not for a compensable injury.

b. The basis for denying or reducing excessive charges and the specific amounts denied or reduced.

c. The basis for denying the charge for an excessive service.

d. The basis for denying a charge as not being medically necessary.

e. A request for records or other information needed to allow proper determination of the bill.

3. Any payment incorrectly made to a provider may be recovered from the provider by the organization.

4. The organization will pay a reasonable fee for a special report as defined in section 92-01-02-29 prepared at the request of the organization. The health care provider or doctor shall include in the special report the time required to prepare the report or the organization may not pay for the report. Time spent and the complexity of the issues will be considered when determining the reasonableness of the fee. Such services should be billed under current procedural terminology code 99080 with a description of "special report".

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45.1. Provider responsibilities and billings.

1. A provider may not submit a charge for a service which exceeds the amount the provider charges for the same service in cases unrelated to workers' compensation injuries.

2. All bills must be fully itemized, including ICD-9-CM codes, and services must be identified by code numbers and descriptions found in the fee schedules or as provided in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition.

3. All medical service providers shall submit bills referring to one claim only for medical services on current form UB 92 or form HCFA 1500, except for dental billings which must be submitted on American dental association J510 dental claim forms. Bills and reports must include:

   a. The claimant's full name and address;

   b. The claimant's claim number and social security number;

   c. Date and nature of injury;

   d. Area of body treated, including ICD-9-CM code identifying right or left, as appropriate;

   e. Date of service;

   f. Name and address of facility where the service was rendered;

   g. Name of medical service provider providing the service;

   h. Physician's or supplier's billing name, address, zip code, telephone number; physician's unique physician identification number (UPIN); physician assistant's North Dakota state license or certification number; physical therapist's North Dakota state license number; advanced practice registered nurse's UPIN or North Dakota state license number;

   i. Referring or ordering physician's UPIN;

   j. Type of service;

   k. Appropriate procedure code or hospital revenue code;

   l. Description of service;

   m. Charge for each service;

   n. Units of service;

   o. If dental, tooth numbers;

   p. Total bill charge;

   q. Name of medical service provider providing service along with the provider's tax identification number; and

   r. Date of bills.

4. All records submitted by providers, including notes, except those provided by an emergency room physician and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim.

5. Providers shall submit with each bill a copy of medical records or reports which substantiate the nature and necessity of a service being billed and its relationship to the work injury, including the level, type, and extent of the service provided to claimants. Documentation required includes:

   a. Laboratory and pathology reports;

   b. X-ray findings;

   c. Operative reports;

   d. Office notes, physical therapy, and occupational therapy progress notes;

   e. Consultation reports;

   f. History, physical examination, and discharge summaries;

   g. Special diagnostic study reports; and

   h. Special or other requested narrative reports.

6. Providers submitting bills for filling prescriptions also shall include the prescribing provider's name on the bill.

7. When a provider submits a bill to the organization for medical services, the provider shall submit a copy of the bill to the claimant to whom the services were provided. The copy must be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the claimant.

8. If the provider does not submit records with a bill, and still does not provide those records upon request of the organization, the charges for which records were not supplied may not be paid by the organization, unless the provider submits the records before the decision denying payment of those charges becomes final. The provider may also be liable for the penalty provided in subsection 6 of North Dakota Century Code section 65-05-07.

9. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted

compensable injury or illness under the jurisdiction of the workers' compensation law, a provider may not pursue payment from a claimant for treatment rendered to that claimant unless the payment for the treatment was denied because:

a. The claimant sought treatment from that provider for conditions not related to the compensable injury or illness.

b. The claimant sought treatment from that provider which was not prescribed by the claimant's attending doctor. This includes ongoing treatment by the provider who is a nonattending doctor.

c. The claimant sought palliative care from that provider not compensable under section 92-01-02-40 after the claimant was provided notice that the palliative care service is not compensable.

d. The claimant sought treatment from that provider after being notified that the treatment sought from that provider has been determined to be unscientific, unproven, outmoded, investigative, or experimental.

e. The claimant did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of doctors before seeking treatment of the work injury from the provider requesting payment for that treatment.

f. The claimant is subject to North Dakota Century Code section 65-05-28.2, and the provider requesting payment is not a preferred provider and has not been approved as an alternative provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

10. A medical service provider may not bill for services not provided to a claimant and may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

11. Pursuant to North Dakota Century Code section 65-05-33, a medical service provider may not submit false or fraudulent billings.

12. Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

13. When a claimant is seen initially in an emergency department and is admitted subsequently to the hospital for inpatient treatment, the services provided immediately prior to the admission are part of the inpatient treatment.

14. A physical medicine modality or manipulation, when applied to two or more areas at one visit, is reimbursed at one hundred percent of the

maximum allowable fee for the first area treated, fifty percent for the second area treated, and twenty-five percent for all subsequent areas treated.

15. When ultrasound, diathermy, microwave, infrared, and hot packs are used in combinations of two or more during one treatment session, only one may be reimbursed, unless two separate effects are demonstrated.

16. When a medical service provider is asked to review records or reports prepared by another medical service provider, the provider shall bill review of the records using CPT code 99080 with a descriptor of "record review". The billing must include the actual time spent reviewing the records or reports and must list the medical service provider's normal hourly rate for the review.

17. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code.

18. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable injury, the organization may reduce the charges submitted for treatment. In addition, the attending doctor must notify the organization immediately and submit:

    a. A description or diagnosis of the non-work-related condition.

    b. A description of the treatment being rendered.

    c. The effect, if any, of the non-work-related condition on the compensable injury.

    The attending doctor shall include a thorough explanation of how the non-work-related condition affects the compensable injury when the doctor requests authorization to treat the non-work-related condition. Temporary treatment of a non-work-related condition may be allowed, upon prior approval by the organization, provided the condition directly delays recovery of the compensable injury. The organization may not approve or pay for treatment for a known preexisting non-work-related condition for which the claimant was receiving treatment prior to the occurrence of the compensable injury, which is not delaying recovery of the compensable injury. The organization may not pay for treatment of a non-work-related condition when it no longer exerts any influence upon the compensable injury. When treatment of a non-work-related condition is being rendered, the attending doctor shall submit reports monthly outlining the effect of treatment on both the non-work-related condition and the compensable injury.

19. In cases of questionable liability when the organization has not rendered a decision on compensability, the provider has billed the claimant or other insurance, and the claim is subsequently allowed, the provider shall refund the claimant or other insurer in full and bill the organization for services rendered.

20. The organization may not pay for the cost of duplicating records when covering the treatment received by the claimant. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a minimum charge of five dollars for five or fewer pages and the minimum charge of five dollars for the first five pages plus thirty-five cents per page for every page after the first five pages.

21. The provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the provider.

22. Billing codes must be found in the most recent edition of the physician's current procedural terminology; health care financing administration common procedure coding system; code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

23. A provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the organization's determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that provider.

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-28.2

92-01-02-46. Medical services disputes.

1. This rule provides the procedures followed for managed care disputes. Restrospective review is the procedure provided for disputing the denial of payment for a medical service charge based on failure to request prior authorization or preservice review. Binding dispute resolution is the procedure provided for disputing managed care recommendations, including palliative care recommendations and bill audit and review. Disputes not arising from managed care follow the reconsideration and hearing procedures provided by North Dakota Century Code section 65-01-16.

2. When the organization denies payment for a medical service charge because the provider did not properly request prior authorization or preservice review for that service, the provider may request a retrospective review of that service. Requests for retrospective review must be made in writing, within thirty days after the notice that payment for the service is denied, addressed to the organization claims analyst assigned to handle the claimant's claim. Requests for retrospective review should not be sent to the managed care vendor. The request must contain:

   a. The claimant's name.

   b. The claim number.

   c. The date of service.

   d. A statement of why the provider did not know and should not have known that the injury or condition may be a compensable injury.

   e. The information required to perform a preservice review or prior authorization of the service.

   If the provider knew or should have known that the patient may have a compensable work injury when the medical services for that injury were provided, the request for retrospective review must be denied. If the provider did not know and should not have known that the patient may have a compensable work injury when the medical services for that injury were provided, a retrospective preservice review or preauthorization must be done in accordance with this chapter. If the organization continues to deny payment for the service, the provider may request binding dispute resolution under this rule.

3. A party who wishes to dispute a utilization review recommendation first shall exhaust any internal dispute resolution procedures provided by the managed care vendor or the utilization review department. A party who wishes to dispute a final recommendation of a managed care vendor or a prior authorization or preservice review decision under section 92-01-02-34 shall file a written request for binding dispute resolution with the organization within thirty days after the final recommendation or decision. The request must contain:

   a. The claimant's name.

   b. The claim number.

   c. All relevant medical information and documentation.

d. A statement of any actual or potential harm to the claimant from the recommendation.

e. The specific relief sought.

4. A party who wishes to dispute a denial or reduction of a service charge arising from bill audit and review must file a written request for binding dispute resolution with the organization within thirty days after the date of the organization's remittance advice reducing or denying the charge. The request must contain:

a. The claimant's name.

b. The claim number.

c. The specific code and the date of the service in dispute.

d. A statement of the reasons the reduction or denial was incorrect, with any supporting documentation.

e. The specific relief sought.

5. The organization shall review the request for binding dispute resolution and the relevant information in the record. The organization may request additional information or documentation. If a party does not provide the requested information within fourteen days, the organization may decide the dispute on the information in the record.

6. The organization may request review by medical service providers, at least one of whom must be licensed or certified in the same profession as the medical service provider whose treatment is being reviewed, or by an external expert in medical coding or other aspects of medical treatment or billing, to assist with its review of the request. The organization may request an independent medical examination to assist with its review of a request.

7. At the conclusion of its review, the organization shall issue its binding decision. The organization shall issue its decision by letter or notice, or for a decision that is reviewable by law, the organization may issue its decision in an administrative order instead of a letter or notice.

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004.
General Authority: NDCC 65-02-08, 65-02-20
Law Implemented: NDCC 65-02-20

92-01-02-47. Providers performing peer review. Repealed effective March 1, 2000.

92-01-02-48. Elements of filing.

1. For purposes of this section, unless the context otherwise requires:

   a. "Appropriate record" means a legible medical record or report from a provider, or any other relevant and material information, substantiating the type, nature, extent, and work-relatedness of an injury, which is adequate to verify the level, type, and extent of services provided.

   b. "Bill" means a provider's statement of charges and services rendered for treatment of a work-related injury.

   c. "Bill review" means the review or audit of medical bills and any associated medical records by workforce safety and insurance and may include review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, and improper concurrent bills for services involving evaluation or treatment of work-related and non-work-related problems.

   d. "Wage verification" means federal and state income tax returns; W-2 forms; daily, weekly, biweekly, semimonthly, or monthly employer payroll statements; and income statements prepared in accordance with generally accepted accounting practices.

2. The elements of filing for an application for workers' compensation benefits are satisfied when the organization has received:

   a. The first report of injury form completed and signed by the employee or the employer, or if the employer's report is deemed admitted pursuant to North Dakota Century Code section 65-01-16 and signed by the provider;

   b. Wage verification as requested by the organization, if disability benefits are claimed; and

   c. Appropriate records from the provider necessary to determine the type, nature, extent, and potential work-relatedness of the injury or disability.

3. The elements of filing for a reapplication are satisfied when the organization is in receipt of:

   a. The C4 form or other correspondence requesting benefits signed by the employee;

b. Wage verification as requested by the organization, if disability benefits are claimed; and

c. Appropriate records from the provider.

4. The elements of filing for payment of a medical bill are satisfied when a bill review is completed and after the organization has received:

a. A bill from the provider or employee; and

b. Appropriate records from the provider or employee.

5. If the organization requests additional information from the employee needed to process a reapplication and the employee does not provide the information, elements of filing are not satisfied until the employee provides the requested information.

6. The organization may waive elements of filing in conjunction with programs established for the expedited processing of selected claims.

History: Effective January 1, 1994; amended effective January 1, 1996; April 1, 1997; February 1, 1998; January 1, 2000; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-49. Determination of employment.

1. Any service performed for another for remuneration under any agreement or contract of hire express or implied is presumed to be employment unless it is shown that the individual performing the service is an independent contractor as determined by the "common law" test.

a. An employment relationship exists when the person for whom services are performed has the right to control and direct the individual person who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so. The right to discharge is a significant factor indicating that the person possessing that right is an employer. The right to terminate a contract before completion to prevent and minimize damages for a potential breach or actual breach of contract does not, by itself, establish an employment relationship. Other factors indicating an employer-employee relationship, although not necessarily present in every case, are the furnishing of tools and the furnishing of a place to work to the person who performs the services. The fact that the contract must be performed at a

specific location such as building site, does not, by itself, constitute furnishing a place to work if the nature of the work to be done precludes a separate site or is the customary practice in the industry. If a person is subject to the control or direction of another merely as to the result to be accomplished by the work and not as to the means and methods for accomplishing the result, the person will likely be an independent contractor. A person performing services as an independent contractor is not as to such services an employee. Persons such as physicians, lawyers, dentists, veterinarians, public stenographers, and auctioneers, engaged in the pursuit of an independent trade, business, or profession, in which they offer their services to the public, are independent contractors and not employees.

b. In determining whether a person is an independent contractor or an employee under the "common law" test, the following twenty factors are to be considered:

(1) Instructions. A person who is required to comply with other persons' instructions about when, where, and how the person is to work is ordinarily an employee. This control factor is present if the person or persons for whom the services are performed have the right to require compliance with instructions.

(2) Training. Training a person by requiring an experienced employee to work with the person, by corresponding with the person, by requiring the person to attend meetings, or by using other methods, indicates that the person or persons for whom the services are performed want the services performed in a particular method or manner.

(3) Integration. Integration of the person's services into the business operations generally shows that the person is subject to direction and control. When the success or continuation of a business depends to an appreciable degree upon the performance of certain services, the persons who perform those services must necessarily be subject to a certain amount of control by the owner of the business.

(4) Services rendered personally. If the services must be rendered personally, presumably the person or persons for whom the services are performed are interested in the methods used to accomplish the work as well as in the results.

(5) Hiring, supervising, and paying assistants. If the person or persons for whom the services are performed hire, supervise, and pay assistants, that factor generally shows control over

the persons on the job. However, if one person hires, supervises, and pays the other assistants pursuant to a contract under which the person agrees to provide materials and labor and under which the person is responsible only for the attainment of a result, this factor indicates an independent contractor status.

(6) Continuing relationship. A continuing relationship between the person and the person or persons for whom the services are performed indicates that an employer-employee relationship exists. A continuing relationship may exist when work is performed at frequently recurring although irregular intervals.

(7) Set hours of work. The establishment of set hours of work by the person or persons for whom the services are performed is a factor indicating control.

(8) Full time required. If the person must devote substantially full time to the business of the person or persons for whom the services are performed, such person or persons have control over the amount of time the person is able to do other gainful work. An independent contractor, on the other hand, is free to work when and for whom the person chooses.

(9) Doing work on the premises of the person or persons for whom the services are performed. If the work is performed on the premises of the person or persons for whom the services are performed, that factor suggests control over the person, especially if the work could be done elsewhere. Work done off the premises of the person or persons receiving the services, such as at the office of the worker, indicates some freedom from control. This fact by itself does not mean that the person is not an employee. The importance of this factor depends on the nature of the service involved and the extent to which an employer generally would require that employees perform such service on the employer's premises. Control over the place of work is indicated when the person or persons for whom the services are performed have the right to compel the worker to travel a designated route, to canvass a territory within a certain time, or to work at specific places as required.

(10) Order or sequence set. If a person must perform services in the order or sequence set by the person or persons for whom the services are performed, that factor shows that the person is not free to follow the person's own pattern of work but must follow the established routines and schedules of the person or persons for whom the services are performed. Often, because of the nature of an occupation, the person

or persons for whom the services are performed to not set the order of the services or set the order infrequently. It is sufficient to show control, however, if such person or persons retain the right to do so.

(11) Oral or written reports. A requirement that the person submit regular or written reports to the person or persons for whom the services are performed indicates control. By contract, however, parties can agree that services are to be performed by certain dates and the persons performing those services can be required to report as to the status of the services being performed so that the person for whom the services are being performed can coordinate other contracts that person may have which are required in the successful total completion of a particular project.

(12) Payment by hour, week, month. Payment by the hour, week, or month indicates an employer-employee relationship, provided that this method of payment is not just a convenient way of paying a lump sum agreed upon as the cost of a job. Payment made by the job or on a straight commission generally indicates that the worker is an independent contractor.

(13) Payment of business or traveling expenses, or both. If the person or persons for whom the services are performed ordinarily pay the person's business or traveling expenses, or both, the person is an employee. An employer, to be able to control expenses, generally retains the right to regulate and direct the person's business activities.

(14) Furnishing of tools and materials. If the person or persons for whom the services are performed furnished significant tools, materials, and other equipment, it is an indication an employer-employee relationship exists.

(15) Significant investment. If the person invests in facilities that are used by the person in performing services and are not typically maintained by employees (such as the maintenance of an office rented at fair value from an unrelated party), that factor tends to indicate that the person is an independent contractor. Lack of investment in facilities indicates dependence on the person or persons for whom the services are performed for such facilities and indicates the existence of an employer-employee relationship.

(16) Realization of profit or loss. A person who may realize a profit or suffer a loss as a result of the person's services (in addition to the profit or loss ordinarily realized by employees)

is generally an independent contractor, but the person who cannot is an employee. If the person is subject to a risk of economic loss due to significant investment or a bona fide liability for expenses, that indicates that the person is an independent contractor. The risk that a person will not receive payment for services, however, is common to both independent contractors and employees and thus does not constitute a sufficient economic risk to support a finding of an independent contractor.

(17) Working for more than one firm at a time. If a person performs services under multiple contracts for unrelated persons or firms at the same time, that generally indicates that the person is an independent contractor. A person who performs services for more than one person may be an employee for each of the persons, especially when such persons are part of the same service arrangement.

(18) Making service available to general public. If a person makes the person's services available to the general public on a regular and consistent basis that indicates an independent contractor relationship.

(19) Right to dismissal. The right to dismiss a person indicates that the person is an employee and the person possessing the right is an employer. An employer exercises control through the right of dismissal, which causes the person to obey the employer's instruction. An independent contractor, on the other hand, cannot be fired without liability for breach of contract so long as the independent contractor produces a result that meets the contract specifications.

(20) Right to terminate. If either person has the right to end the relationship with the person for whom the services are performed at any time the person wishes without incurring liability, that indicates an employer-employee relationship. If a contract can be terminated by the mutual agreement of the parties before its completion or by one of the parties to the contract before its completion to prevent a further breach of contract or to minimize damages, that indicates an independent contractor relationship.

2. The factors described in paragraphs 3, 6, 15, 16, 17, 18, 19, and 20 of subdivision b of subsection 1 must be given more weight in determining whether an employer-employee relationship exists.

History: Effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-03

92-01-02-49.1. Determination of employment status. A person may apply to the organization for a determination of whether that person is an employer as that term is defined by North Dakota Century Code title 65. A person claiming not to be an employer under the Workers' Compensation Act has the burden of proving by a preponderance of the evidence that the person is not an employer. The request for a determination must be in writing and must be supported by evidence of the employment status of the requesting party. If the party is asserting an independent contractor relationship, the party must submit copies of written contracts, if any, establishing the relationship. The organization may request, and the party shall provide promptly, any additional relevant information bearing on the issue of the employer status of the party. After review of the evidence, the organization shall issue its decision determining the employment status of the requesting party under North Dakota Century Code title 65. This determination is effective for no more than one year from the date of the decision and may be reconsidered or revoked at any time by the organization. The requesting party has a continuing obligation to notify the organization of any material change in that party's business relationships, and a failure to notify the organization of a material change shall nullify the organization's certification as of the date of the change.

History: Effective January 1, 1996; amended effective May 1, 1998.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-09-01

92-01-02-50. Other states' coverage.

1. The terms used in this section have the same meaning as in North Dakota Century Code title 65 and in North Dakota Administrative Code title 92, except:

   a. "Covered employment" means hazardous employment principally localized in this state which involves incidental operations in another state. The term "covered employment" does not include employment in which the employer is required by the laws of that other state to purchase workers' compensation coverage in that other state.

   b. "Employee" means any North Dakota employee as that term is defined in North Dakota Century Code section 65-01-02 who engages in covered employment and who is eligible to file for workers' compensation benefits in another state if the employee suffers a work-related illness or injury or dies as a result of work activities in that state. The term "employee" also includes a person with optional workers' compensation coverage in this state under North Dakota Century Code section 65-04-29 or 65-07-01 who engages in covered employment and is eligible to file for workers' compensation benefits in another state if that person suffers a work-related illness or injury or dies as a result of work activities in that state.

c. "Employer" means an employer as defined in North Dakota Century Code section 65-01-02, who is not materially delinquent in payment of premium, and who has employees engaged in covered employment. An employer is not materially delinquent in payment of premium if the premium is no more than thirty days delinquent.

d. "Incidental operations" in a state other than a qualified state means business operations of an employer for fewer than thirty consecutive days in which the employer has no contacts sufficient, under the workers' compensation laws of that other state to subject the employer to liability for payment of workers' compensation premium in that other state and which operations do not require the employer to purchase workers' compensation insurance under the laws of that state.

e. "Incidental operations" in a qualified state means operations of an employer for fewer than thirty days in a state in which the employer has no other significant contacts. "Significant contacts" in a qualified state means operations of an employer in that state for thirty or more consecutive days.

f. "Qualified state" means a state in which an insurance company, formed pursuant to North Dakota Century Code chapter 65-08.1, is qualified to sell, and does sell, workers' compensation insurance.

2. If an employee, hired in this state for covered employment by an employer covered by the Workers' Compensation Act of this state, receives an injury while employed in incidental operations outside this state, the injury is subject to the provisions of this section if the employee elects to receive benefits under the workers' compensation laws of that other state in lieu of a claim for benefits in this state. This section applies only if the workers' compensation laws of the other state allow the employee to elect to receive benefits under the laws of that state. If the employee does not or cannot elect coverage under the laws of another state, the injury is subject to the provisions of North Dakota Century Code chapter 65-08.

The provisions of this section do not apply to:

a. States having a monopolistic state fund.

b. States having a reciprocal agreement with this state regarding extraterritorial coverage.

c. Compensation received under any federal act.

d. Foreign countries.

e. Maritime employment.

f. Employer's liability or "stop-gap" coverage.

3. An employee who elects to receive benefits under the workers' compensation laws of another state waives the right to seek compensation under North Dakota Century Code title 65.

4. The organization may pay, on behalf of an employer, any regular workers' compensation benefits the employer is obligated to pay under the workers' compensation laws of a state other than North Dakota, with respect to personal injury, illness, or death sustained as a result of work activities by an employee engaged in covered employment in that state, if the employee or the employee's dependents elect to receive benefits under the other state's laws in lieu of benefits available under the North Dakota Workers' Compensation Act. The term "dependents" includes an employee's spouse. The organization may pay benefits on behalf of an employer but may not act nor be deemed as an insurer, nor may the organization indemnify an employer for any liabilities, except as specifically provided in this section.

   The benefits provided by this section are those mandated by the workers' compensation laws of the elected state. This includes benefits for injuries that are deemed compensable in that other state but are not compensable under North Dakota Century Code chapters 65-05 and 65-08. Medical benefits provided pursuant to this section are subject to any fee schedule and other limitations imposed by the workers' compensation law of the elected state. The North Dakota fee schedule does not apply to this section.

   The organization may reimburse an employer covered by this section for legal costs and for reasonable attorney's fees incurred, at a rate of no more than eighty-five dollars per hour, if the employer is sued in tort in another state by an injured employee or an injured employee's dependents relative to a work-related illness, injury, or death; or if the employer is alleged to have failed to make payment of workers' compensation premium in that other state by the workers' compensation authorities of that state. This reimbursement may be made only if it is determined by the organization or by a court of competent jurisdiction that the employer is subject to the provisions of this section and was not required to purchase workers' coverage in that other state relative to the employment of the injured employee.

   The organization may not reimburse any legal costs, attorney's fees, nor any other costs to a coemployee sued in tort by an injured employee.

5. The organization may contract with a qualified third-party administrator to adjust and administer claims arising under this chapter. The

organization shall pay the costs of the third-party administrator from the general fund.

6. Benefits paid on behalf of an employer pursuant to this section will be charged against the employer's account for experience rating purposes. The experience rating loss will be equal to the actual claim costs. The assessment charge plus appropriate penalties and interest, if any, levied pursuant to North Dakota Century Code section 65-05-07.2, will be assessed on all claims brought under this section.

7. The employer shall notify the organization when a claim is filed in another state by an employee covered by this section. The employer shall notify the organization of the claim in writing. The employer has thirty days after actual knowledge of the filing of a claim in which to notify the organization. That time can be extended for thirty days by the organization if the employer shows good cause for failing to timely notify the organization. If the employer fails to timely notify the organization when a claim is filed in another state by an employee covered under this section, the organization may not pay benefits under this section.

   The organization may not pay costs, charges, or penalties charged against an employer for late reporting of an injury or claim to the workers' compensation authorities of the state of injury.

8. The exclusive remedy provisions of North Dakota Century Code sections 65-01-01, 65-01-08, 65-04-28, and 65-05-06 apply to this section.

History: Effective January 1, 1994; amended effective April 1, 1997; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

92-01-02-51. Amnesty period for employers, employees, and providers. Repealed effective July 1, 2006.

92-01-02-51.1. Payment of copies requested by subpoena. Any person, as defined in North Dakota Century Code section 1-01-49, served with a subpoena by the organization which directs the production of copies of documents may charge the organization copying costs. Those persons shall charge, and the organization shall pay, no more than twenty-five cents per page and up to ten hours for labor not to exceed twenty-five dollars per hour. A payment for copies may exceed the amounts listed herein if, in the discretion of the organization, the production has been or will be uniquely taxing.

History: Effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-11

92-01-02-51.2. Work defined. As used in subsection 3 of North Dakota Century Code section 65-05-08 and North Dakota Century Code section 65-05-33, "work" means physical or mental effort exerted to do or to make something for any amount of remuneration or physical or mental effort exerted to do or to make something that a reasonable person would consider commonly done or made for remuneration.

History: Effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08(3), 65-05-33

92-01-02-52. Procedure for penalizing delinquent employer accounts. Repealed effective May 1, 2002.

92-01-02-53. Workforce safety and insurance scholarship fund - Application criteria - Refund. An applicant for a workers' compensation scholarship offered under section 65-05-20.1 must complete the application form required by the organization. The scholarship committee will use the information on the application form to determine which applicants receive the scholarship and may require an applicant to submit additional supporting information. The minimum required grade point average is a two point zero on a four point zero scale, or its equivalent. The organization may award individual scholarships in any amount up to the maximum amounts provided in North Dakota Century Code section 65-05-20.1. Applicants who are awarded the scholarship one year must reapply to receive the scholarship in a subsequent year. If the amount awarded to the applicant is greater than the amount owed the institution over the course of the school year, the excess award must be refunded to the organization. If the applicant who is awarded a scholarship withdraws from the institution and there are scholarship funds to be refunded, the institution shall refund those funds to the organization according to the refund priorities of the institution.

History: Effective August 1, 1997; amended effective May 1, 2000; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-20.1

92-01-02-54. Deductible programs. The organization and an employer may contract for a deductible program. When a deductible program contract is entered, the employer shall reimburse the organization for benefits payable on individual claims up to the agreed deductible amount. The organization shall provide a reduced premium to participating employers based on an actuarial analysis of the contracted deductible and the rate classification of the employer. For purposes of calculating premiums, the experience rate utilized will exclude actual and expected primary losses.

For an additional premium, the organization may provide aggregate excess coverage limiting the maximum liability for losses of the employer during a policy period. Premiums will be derived from actuarial analysis and a selected aggregate limit. The aggregate limit will be agreed upon by the employer and the organization.

1. **Eligibility.** Eligibility for participation in a deductible program is based on the financial stability and resources of the employer. Participating employers must be in good standing with the organization.

   The organization may require participating employers to submit to a financial audit to ensure financial stability. The audit may include a credit check and review of company financial reports.

   The organization shall analyze each proposed contract based on risk analysis and sound business practices. The organization may refuse any deductible program if it determines that the proposed contract does not represent a sound business practice or decision. Past participation in a deductible program does not guarantee continued eligibility. The organization may decline renewal of any deductible program.

2. **Claim payment.** The organization shall process and pay claims in accordance with North Dakota Century Code title 65. The employer shall reimburse the organization for all costs paid by the organization on individual claims up to the amount of the contractually agreed deductible.

   If a third-party recovery on a claim is made, the recovery will be allocated according to the terms of the contractual agreement between the organization and the employer, subject to North Dakota Century Code section 65-04-19.3.

   The organization shall deduct any delinquent deductible reimbursements from any subrogation amounts recovered on any claim.

3. **Premium payment.** Premium is due at policy inception pursuant to the terms of the contractual agreement between the organization and the employer.

4. **Financial security.** The organization may require an employer to provide a bond, letter of credit, or other security approved by the organization to guarantee payment of future employer obligations incurred by a deductible contract.

History: Effective May 1, 2000; amended effective May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-55. Dividend programs. The organization may offer dividends to qualifying employers. Eligibility and distribution:

1. Dividends are not guaranteed. Dividends may only be declared by the workforce safety and insurance board of directors.

2. If an employer's account has been in effect for less than an entire premium year, any dividend offered shall be prorated by the number of months the employer's account has been active with the organization. Premiums paid and losses incurred during a dividend review period defined by the organization, and other criteria identified by the organization, may be used to determine the amount of the dividend. Minimum premium and volunteer accounts are not eligible for dividend payments.

3. The organization shall offset past-due balances on any account by the dividend earned on that account.

4. The distribution of a dividend may not reduce an employer's premium below the minimum premium.

History: Effective May 1, 2000; amended effective July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-56. Retrospective rating program. The organization and an employer may elect to contract for a retrospective rating program. Under a retrospective rating program, the employer's retrospective rating premium is calculated using factors including claims costs and actual standard premium and basic premium factors. The organization shall calculate basic premium factors for each level of premium and maximum employer liability.

Retrospective rating contracts may provide for the calculation of employer or organization interest credits and debits pertaining to claims payments, deposits, or premium balances.

1. **Eligibility**. Eligibility for participation in a retrospective rating program is based on the financial stability and resources of the employer. Participating employers must be in good standing with the organization.

   The organization may require participating employers to submit to a financial audit performed to ensure financial stability. The audit may include a credit check and review of company financial reports.

   The organization shall analyze each proposed contract based on risk analysis and sound business practices. The organization may refuse a retrospective rating program if it is determined that the proposed contract does not represent a sound business practice or decision.

   Past participation in a retrospective rating program does not guarantee continued eligibility. The organization may decline renewal of any retrospective rating program.

2. **Retrospective rating program.** A participating employer chooses one maximum liability limit per account. The retrospective rating program

applies to the account's entire premium period. The retrospective rating program option is based on aggregate claims costs for all claims for injury or death occurring in the contract year.

3. **Claim payment.** The organization shall process and pay claims in accordance with North Dakota Century Code title 65. If a third-party recovery on a claim is made, the organization's subrogation interest must first be applied to the amounts paid on the claim by the organization. If the subrogation recovery reduces the retrospective premium, the organization shall provide a refund to the employer.

4. **Premium payment.** Premium is due at policy inception.

5. **Financial security.** The organization may require an employer to provide a bond, letter of credit, or other security approved by the organization to guarantee payment of future employer obligations incurred by a retrospective rating contract. The amount of the security may not exceed the initial nonpaid portion of the maximum possible retrospective premium.

History: Effective May 1, 2000; amended effective May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-17.1

92-01-02-57. Medical expense assessments. An employer may file an incident report with the organization through the organization's web site. If an incident report is filed with the organization by midnight central time of the next organization business day following the workplace injury or incident and a claim is filed for benefits within ten calendar days of the date of injury, the organization shall waive the two hundred fifty dollar medical expense assessment.

The organization shall notify an employer by regular mail of the employer's medical expense assessment billing statement or by electronic transmission of the organization's decision to assess a medical expense assessment against an employer's account. The billing statement must inform the employer of the ability to appeal the decision of the organization.

History: Effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3, 65-05-07.2

WORKFORCE SAFETY AND INSURANCE

PERMANENT MENTAL IMPAIRMENT RATING REPORT

WORK SHEET

Since the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, does not provide a quantified method for assigning permanent impairment percentages under Chapter 14, "Mental and Behavioral Disorders", the evaluating physician shall utilize this form. When using this form, the evaluating physician shall:

a. Become familiar with the content of the work sheet and develop an understanding of the percentages and categories listed in "I. Level of Permanent Mental Impairment" and Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition;

b. Enter the permanent mental category rating associated with each item in all sections of "II. Areas of Function" as it applies to the injured worker; and

c. Enter a rating for the "Overall Permanent Impairment Rating" provided within this appendix. The "Overall Permanent Impairment Rating" must be based upon the categories provided in Table 14-1.

d. All permanent impairment reports must include the cause of the impairment and must contain an apportionment if the impairment is caused by both work and non-work injuries or conditions.

The various degrees of permanent impairment from "II. Areas of Function" on within this appendix are not added, combined, or averaged. The overall mental rating should be based upon clinical judgment and Table 14-1, and be consistent with other chapters of the AMA guides.

–PLEASE PHOTOCOPY AS NEEDED–

PERMANENT MENTAL IMPAIRMENT RATING

REPORT WORK SHEET

Patient Name _____ DOB _____

WC# _____ SSN _____

I. LEVELS OF PERMANENT MENTAL IMPAIRMENT - as identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Percent	Category
0%	Class 1. No Impairment
1-15%	Class 2. Mild Permanent Impairment
16-25%	Class 3. Moderate Permanent Impairment
26-50%	Class 4. Marked Permanent Impairment
51-100%	Class 5. Extreme Permanent Impairment

II. AREAS OF FUNCTION

1. Activities of Daily Living

_____ Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing oneself, bathing, eating, preparing meals, and feeding oneself)

_____ Communication (writing, typing, seeing, hearing, speaking)

_____ Physical activity (standing, sitting, reclining, walking, climbing stairs)

_____ Travel (driving, riding, flying)

_____ Nonspecialized hand activities (grasping, lifting, tactile discrimination)

_____ Sexual function (orgasm, ejaculation, lubrication, erection)

_____ Sleep (restful, nocturnal sleep pattern)

2. Social Functioning

_____ Get along with others

_____ Initiate social contacts

_____ Communicate clearly with others

_____ Interact and actively participate in group activities

_____ Cooperative behavior, consideration for others, and awareness of others' sensitivities

_____ Interacts appropriately with the general public

_____ Asks simple questions or requests assistance

_____ Accepts instructions and responds appropriately to criticism from supervisors

_____ Gets along with coworkers and peers without distracting them or exhibiting behavioral extremes

_____ Maintains socially appropriate behavior

_____ Adheres to basic standards of neatness and cleanliness

3. Memory, Concentration, Persistence, and Pace

_____ Comprehend/follow simple commands

_____ Works with or near others without being distracted

_____ Sustains an ordinary routine without special supervision

_____ Ability to carry out detailed instructions

_____ Maintain attention and concentration for specific tasks

_____ Makes simple work-related decisions

_____ Performs activities within a given schedule

_____ Maintains regular attendance and is punctual within customary tolerances

_____ Completes a normal workday and workweek without interruptions from psychologically based symptoms

_____ Maintains regular attendance and is punctual within customary tolerances

4. Deterioration or Decompensation in Complex or Worklife Settings (Adaptation to Stressful Circumstances)

_____ Withdraws from the situation or experiences exacerbation of signs and symptoms of a mental disorder

_____ Decompensates and has difficulty maintaining performance of activities of daily living (ADLs), continuing social relationships, or completing tasks

_____ Able to make good autonomous decisions/exercises good judgment

_____ Perform activities on schedule

_____ Interacts appropriately with supervisors and peers

_____ Responds appropriately to changes in work setting

_____ Aware of normal hazards and takes appropriate precautions

_____ Able to use public transportation and can travel to and within unfamiliar places

_____ Sets realistic goals

_____ Makes plans independent of others

OVERALL PERMANENT IMPAIRMENT RATING _____

IMPAIRMENT CAUSED BY WORK _____

Physician _____ Date _____

(signature)

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING REPORT WORK SHEET